

Wisconsin Department of Regulation & Licensing

Mail To: P.O. Box 8935
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1400 E. Washington Avenue
Madison, WI 53703
E-Mail: web@drl.state.wi.us
Website: http://drl.wi.gov

PHARMACY EXAMINING BOARD

APPLICATION FOR DISTRIBUTOR OF PRESCRIPTION DRUG LICENSE

Current License Number _____ ☐ New Facility ☐ Change of Ownership ☐ Change of Location

PLEASE TYPE OR PRINT IN INK

SECTION A (attach an extra sheet if necessary):

APPLICANT (individual, partnership, association or corporation):

APPLICANT'S ADDRESS:

APPLICANT'S TELEPHONE NO.: () _____ - _____

DBA (name or title under which business is operated):

DISTRIBUTION CENTER ADDRESS (number, street, city, zip code):

BUSINESS PHONE: () _____ - _____

NAME OF CONTACT PERSON: _____

Name of Owner or Name & Title of All Partners or Corporate Officers, % of Ownership, and Directors

<u>Name</u>	<u>Title</u>	<u>Percentage</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Date Established or Incorporated: _____

Place Established or State Incorporated: _____

APPLICATION FEE:

Make check payable to Department of Regulation and Licensing and attach to this application.

\$53.00

For Receipting Use Only

Wisconsin Department of Regulation & Licensing

Other Firm Names Under Which Business is Conducted and Their Location:

Name

Location

_____	_____
_____	_____
_____	_____

Name and Position of Person Responsible for the Distribution of Prescription Drugs and/or Devices:

<u>Name</u>	<u>State of Licensure (if applicable)</u>	<u>License #</u>	<u>Position</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

SECTION B: Submit with this application a listing or product catalog of the products you currently distribute as well as a description of the applicant's past experience in the manufacture or distribution of any drugs or devices, and any controlled substances.

SECTION C:

MARK AN 'X' IN THE APPROPRIATE BOX, COMPLETE BLANKS AND/OR ATTACH SHEETS AS APPROPRIATE

- | | | |
|---|----------------------------|--------------------------|
| | YES | NO |
| 1. Is applicant now or has applicant ever been credentialed by a federal or state agency? If yes, complete below: | <input type="checkbox"/> | <input type="checkbox"/> |
| <u>Agency</u> | <u>Registration Number</u> | <u>Expiration Date</u> |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| 2. Is applicant a manufacturer and/or repackager of (prescription, non-prescription) drugs? If yes, indicate your Food & Drug Administration Registration Number: _____ Expiration Date: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Is applicant a manufacturer and/or repackager of controlled substances? If yes, indicate your Food & Drug Administration Registration Number: _____ Expiration Date: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have any of the principals previously been licensed by the Wisconsin Pharmacy Examining Board? If yes, give name, license number and location: _____
Is above facility closed? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have any of the principals ever been convicted of a felony or misdemeanor? If yes, attach a sheet providing details about the pending charge, copy of the court documents and status of the charge and complete Convictions and Pending Charges Form #2252. | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have any of the principals had their pharmacists, pharmacy, manufacturer or distributor license suspended, revoked, or reprimanded in this or any other state? If yes, attach a sheet providing details about the action, including the name of the credentialing agency and date of action. | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do any of the principals have a pharmacy, pharmacist, manufacturer or distributor license now subject to disciplinary proceedings in this or any other state? If yes, attach a sheet providing details about pending action, including the name of the agency and status of action. | <input type="checkbox"/> | <input type="checkbox"/> |

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AFFIDAVIT OF APPLICANT

The undersigned, having been duly sworn on oath, states that the facts and statements herein contained are true and correct based upon personal knowledge of the undersigned.

Applicant Signature

Date

State of _____

County of _____

Subscribed and sworn before me this ____ day
of _____, 20____
by _____
(applicant)

S E A L

Notary Public, State of _____
My Commission Expires: _____

NOTE: This affidavit must be signed by the applicant in the presence of the notary public on the same date.